INS AND OUTS OF MID-LEVEL PROVIDER BILLING

Presented by:
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OBJECTIVES

- Describe scopes of practice for Nurse Practitioners and Physician Assistants
- Discuss documentation challenges for split/shared visits and incident to billing
- Review guidelines for billing for an assistant at surgery
WHO IS A MID-LEVEL PROVIDER?

- Physician Assistant (PA)
- Nurse Practitioner (NP)
- Clinical Nurse Specialist (CNS)
- Certified Nurse-Midwives (CNM)
- Certified Registered Nurse Anesthetists (CRNA)
- Physical Therapists (PT)
- Clinical Psychologist (LCP)
- Clinical Social Worker (LCSW)

NURSE PRACTITIONER (NP)

- Registered professional nurse who is prepared, through advanced education and clinical training, to provide a wide range of preventive and acute health care services to individuals of all ages
- American College of Nurse Practitioners (ACNP)
**Physician Assistant (PA)**

- Medical professional who is a graduate of an accredited Physician Assistant (PA) educational program and who is nationally certified and state-licensed to practice medicine with the supervision of a physician
  - American Academy of Physician Assistants (AAPA)

**History – Nurse Practitioners (NPs)**

- **1940s**
  - Physicians begin to collaborate and seek help of nurses in administering primary care to patients

- **1950s**
  - More physicians begin specializing, resulting in an increased shortage of primary care physicians
  - Introduction of Medicare and Medicaid; more people begin seeking primary care

- **1965**
  - Nursing leaders suggest expanding role and duties of qualified and trained nurses
  - First training program for NPs was created at University of Colorado
HISTORY – NURSE PRACTITIONERS (NPs)

1971
- US Secretary of Health, Education and Welfare makes a formal recommendation stating that NPs are qualified to serve as primary care providers

1980s
- National certifying agencies begin playing a more active role in preparing NPs, establishing master's degrees as the educational qualification need to become a Certified Nurse Practitioner

1990s
- NPs are able to show the world that the primary care services they provide are beneficial and not inferior to those provided by medical doctors

1997
- Congress grants approval for nurse practitioners to receive direct Medicare and Medicaid reimbursement

2008
- The Advanced Practice Registered Nurse (APRN) Consensus Model is developed and defines the NP scope of practice to include independent practice and prescriptive authority
- 24 state Boards of Nursing adopt a similar definition

2012
- The number of NPs practicing in the United States nears 150,000
- 52% of NPs practice primary care
HISTORY – PHYSICIAN ASSISTANTS (PAs)

1961 • Proposal for “an advanced medical assistant with special training, who could take some degree of medical responsibility”

1965 • First “Physician Assistant” educational program is established at Duke University

1967 • First program to train surgical PAs (surgeon’s assistants) founded at University of Alabama - Birmingham

1971 • American Medical Association (AMA) recognizes the PA profession and begins to work on national certification

1980 • Nearly 7,000 PAs in the United States
• Physician assistants have prescriptive authority in 10 states

1997 • PAs are recognized as Medicare and Medicaid covered providers in all settings
HISTORY – PHYSICIAN ASSISTANTS (PAs)

2000 • All 50 states now authorize PA practice

2007 • All 50 states now allow PAs to prescribe

2012 • The number of Physician Assistants practicing in the US is over 83,000
     • 43% work in primary care

SCOPES OF PRACTICE
WHAT IS SCOPE OF PRACTICE?

- The legally authorized parameter of the clinical functions of assessment, intervention and level of care a healthcare practitioner can provide to a patient

- Scope of practice varies by state regulations

PHYSICIAN COLLABORATION

- Collaboration is the process in which a NP works with one or more physicians to deliver health care services within the scope of the practitioner’s expertise
  - Includes medical direction and appropriate supervision as provided for in jointly developed guidelines or other mechanisms as provided by state law
  - 42 CFR § 410.75(1)
**PHYSICIAN SUPERVISION**

- Overseeing the activities of and accepting responsibility for the medical services rendered by a physician assistant
  - American Academy of Physician Assistants (AAPA)

**WRITTEN PROTOCOL**

- Jointly developed written statement
  - Includes problems and conditions likely to be encountered and the appropriate treatment for these problems and conditions
- Protocol will establish a practice specific range of approved tasks, problems and conditions, including prescription of any medication if delegated
  - Tennessee Board of Examiners, Rule 0880-3-.01 (32)
NP Scope of Practice

- **Independent Practice**
  - 18 states allow NPs to practice independently without physician oversight or collaboration
  - 6 states allow NPs to practice independently with the exception of prescriptive authority

- **Physician Collaboration**
  - 9 states require physician collaboration
  - 10 states require physician collaboration and a written protocol

NP Scope of Practice

- **Physician Supervision**
  - 6 states require physician collaboration, supervision and a written protocol
  - 2 states require physician supervision and a written protocol
NP Scope of Practice

- State law
  - Illinois—225 ILCS 65-35
    - A written collaborative agreement is required for all advanced practice nurses engaged in clinical practice, except for advanced practice nurses who are authorized to practice in a hospital or ambulatory surgical treatment center.
NP Scope of Practice

- State law
  - Missouri - 20 CSR 2200-4.200, (3)(H)
    - When a collaborative practice arrangement is utilized to provide health care services for conditions other than acute self-limited or well-defined problems, the collaborating physician, or other physician designated in collaborative practice arrangement, shall examine and evaluate the patient and approve or formulate the plan of treatment for new or significantly changed conditions as soon as is practical, but in no case more than two (2) weeks after the patient has been seen by the collaborating APRN or RN.

PA Scope of Practice

- Physician Supervision
  - Every state requires PAs to practice with physician supervision
  - State laws grant physicians broad delegatory authority
  - State regulations and statutes differ regarding specific supervision requirements
PA Scope of Practice

State law

- Arkansas – 60 ARK. CODE R. 24(6)
  - Supervising physician to be available for immediate telephone contact; must be able to reach location where PA is seeing patients within 1 hour

- Illinois – 225 ILL. COMP. STAT 95/4
  - Supervision of the PA shall not be construed to necessarily require the physical presence of the supervising physician at all times at the place where services are rendered, as long as communication available for consultation by radio, telephone or telecommunications
PA Scope of Practice

State law

- Indiana – IND. CODE §25.27.5.2-14
  - The supervising physician or physician designee is physically present at the location at which the PA performs services
  - The supervising physician or designee is immediately available for consultation, and is either in the county of or in a contiguous county to the on-site location in which services are rendered or tasks are performed by the PA

- Missouri - MO. REV. STAT. §334.735
  - Supervision is defined as control exercised over a PA working within the same facility as the supervising physician 66% of the time a PA provides patient care, except that a PA may make follow-up patient examinations in hospitals, nursing homes and correctional facilities, each such exam being reviewed, approved and signed by the supervising physician
  - Supervising physician must be readily available in person or via telecommunication during the time the PA is providing patient care
PA Scope of Practice

State law

- Wisconsin - WIS. ADMIN. CODE §8.10
  - Supervising physician or substitute shall be available at all times for consultation either in person or within 15 minutes by telecommunication or electronic other means
  - Supervising physician must visit and review on-site any facilities attended by PA at least once a month
  - Any patient in location other than physician’s main office shall be attended personally by physician consistent with the patient’s medical needs

Reimbursement
MEDICARE REIMBURSEMENT

- Physician Assistants and Nurse Practitioners are paid for covered services at 85% of the allowed amount on the Medicare Physician Fee Schedule (MPFS)
  - Medicare Claims Processing Manual 100-04, Chapter 12, 110 – 120

- Nurse Practitioners
  - Direct billing and payment for NP services may be made the NP
    - NP may reassign payment

- Physician Assistants
  - Payment for services of a PA may be made only to the actual qualified employer of the PA
    - PAs may not bill Medicare directly for their services
    - PAs may not reassign payment

- Medicare Benefit Policy Manual 100-02, Chapter 15, 190 - 200
MEDICAID REIMBURSEMENT

- Reimbursement varies by state
  - 70% - 100% of physician rate

- Reimbursement restrictions may apply

- Modifiers may be needed to indicate the service was performed by a NP or PA

INCIDENT TO SERVICES
INCIDENT TO SERVICES

- Services or supplies that are furnished as an integral, although incidental, part of the physician’s personal professional services in the course of diagnosis or treatment of an injury illness
  - Medicare Benefit Policy Manual 100-02, Chapter 15, 60.1

INCIDENT TO SERVICES

- Applicable Settings
  - Physician’s office
  - Patient’s home

- Hospital services incident to physician’s or other practitioner’s services are payable under Part B to a hospital
INCIDENT TO SERVICES

Direct Personal Supervision

- Coverage of services and supplies provided incident to is limited to situations in which there is direct physician supervision
  - Supervising physician must have a relationship with legal entity billing and receiving payment for the services or supplies that satisfies the requirements for valid reassignment

Direct Personal Supervision (continued)

- Direct supervision in the office setting does not mean that the physician must be present in the same room
- The physician must be present in the office suite and immediately available to provide assistance and direction
- Medicare Benefit Policy Manual 100-02, Chapter 15, 60.1B
INCIDENT TO SERVICES

- Services of Nonphysician Personnel
  Furnished Incident to Physician’s Services
  - Must have been a direct, personal, professional service furnished by physician to initiate course of treatment
  - Must be subsequent services by physician of a frequency that reflects the physician’s continuing active participation in and management of the course of treatment
  - Medicare Benefit Policy Manual 100-02, Chapter 15, 60.2

INCIDENT TO SERVICES

- Incident to Requirements
  - Established patient
  - Established problem with established plan of care
  - Physician must be present in office suite and immediately available

- If requirements are met, NPP may bill services under physician’s provider number
INCIDENT TO SERVICES

Physician Directed Clinic
- A physician (or number of physicians) is present to perform medical (rather than administrative) services at all times the clinic is open
- Each patient is under the care of a clinic physician
- The nonphysician services are under medical supervision

INCIDENT TO SERVICES

Physician Directed Clinic
- In highly organized clinics, particularly those that are departmentalized, direct physician supervision may be the responsibility of several physician as opposed to an individual attending physician
- The physician ordering a particular service need not be physician supervising service
- Medicare Benefit Policy Manual 100-02, Chapter 15, 60.3
Physician supervision requirements for hospital outpatient diagnostic services

- General Supervision
  - Procedure is furnished under the physician’s overall direction and control, but physician’s presence is not required during performance of procedure
- Direct Supervision
  - Physician is present in office suite and immediately available to furnish assistance and direction throughout performance of procedure

Physician supervision requirements for hospital outpatient diagnostic services (continued)

- Personal Supervision
  - Physician must be in attendance in the room during procedure

Supervision levels are assigned to each CPT or Level II HCPCS code in the Medicare Physician Fee Schedule Relative Value File

- Medicare Benefit Policy Manual 100-02, Chapter 15, 80
CONCEPTS TO PONDER...

- Direct Physician Supervision
  - What constitutes an office suite?
  - What does it mean by “immediately available”?

INCIDENT TO SERVICES

- Noridian Administrative Services
  - “Immediately available” – “without delay”
  - “Office suite” – limited to dedicated area, or suite, designated by records of ownership, rent or other agreement with the owner, in which the supervisory physician maintains his/her practice or provides his/her services as part of a multi-specialty clinic

- [https://www.noridianmedicare.com/provider/updates/docs/IncidentTo_billing_and_terms_acro.pdf](https://www.noridianmedicare.com/provider/updates/docs/IncidentTo_billing_and_terms_acro.pdf)
INCIDENT TO SERVICES

- Cahaba Government Benefit Administrators
  - Office suite – space that is owned or leased by the “incident to” physician (or his/her group) which corresponds to the enrolled (on file) place of service
  - Physician signature indicates physician’s continued active involvement in patient’s course of treatment

SPLIT/SHARED VISITS
SPLIT/SHARED VISITS

- Medically necessary encounter where the physician and a qualified NPP each personally perform a *substantive* portion of an evaluation and management (E/M) visit face-to-face with the same patient on same date of service
  - Medicare Claims Processing Manual 100-04, Chapter 12, 30.6.13H

SUBSTANTIVE PORTION

- Key Components of an E/M Visit
  - History
  - Exam
  - Medical Decision Making
SPLIT/SHARED VISITS

- Applicable Settings
  - Hospital inpatient, outpatient, observation, discharge
  - Emergency department
  - Office and non-facility visits

- Split/shared visits *cannot* be reported for:
  - Services in a Skilled Nursing Facility (SNF) or Nursing Facility (NF)
  - Critical care services (CPT codes 99291 – 99292)
  - Procedures

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SPLIT/SHARED VISITS

- Office/Clinic Setting
  - When an E/M service is a shared/split encounter between a physician and a NPP, the service is considered to have been performed "incident to" if requirements for "incident to" are met
    - Medicare Claims Processing Manual 100-04, Chapter 12, 30.6.1B

  - If "incident to" requirements are *not* met, bill under NPP
SPLIT/SHARED VISITS

- Documentation Requirements
  - Must clearly identify both the physician and non-physician practitioner (NPP)
  - Documentation must support E/M components performed by each provider
  - Be within scope of practice

SPLIT/SHARED VISITS

- Wisconsin Physicians Service
  - Both physician and NPP must each personally perform part of the visit and both the physician and the NPP must document the part(s) that he or she personally performed
  - Example of inadequate documentation by the physician:
    - I have personally seen and examined the patient independently, reviewed the PA's hx, exam and MDM and agree with assessment and plan as written
SPLIT/SHARED VISITS

- **Novitas Solutions**
  - The physician must document at least one element of history, exam and/or medical decision making component of the E/M service
  - "It is not sufficient for the physician to simply document 'seen and agree' or simply countersign. The physician must document what he/she personally performed during the E/M service."


SCRIBING

- "Scribe" situations are those in which the physician utilizes the services of his, or her, staff to document work performed by that physician
- A "scribe" does not act independently, but simply documents the physician’s dictation and/or activities during the visit

**Rural Health Clinics**

- Clinics located in areas designated by Bureau of Census as rural and by the Secretary of Department of Health and Human Services (DHHS) or the State as medically underserved

- Applies to Medicare and Medicaid
RHC CRITERIA

- Designated as a rural area
- Employ a NP or PA
  - At least 50% of operating clinic hours
- Directly furnish routine diagnostic and lab tests
- Two types of RHCs
  - Provider Based Clinic
  - Independent Clinic

RHC BILLING

- Part A Services
  - Revenue Code (521) / CMS-1450 (UB-04)
  - Physician services or services provided incident-to the physician (NP or PA services are billed to Medicare Part A)
  - Provider based clinics – technical charges
RHC BILLING

- Part B Services
  - Routine diagnostic services
  - Lab services
  - Independent clinics – technical charges

- Medicare Claims Processing Manual 100-04
  Chapter 9

ASSISTANT AT SURGERY
ASSISTANT AT SURGERY

- Physician or NPP who actively assists the physician in charge of a case in performing a surgical procedure
  - The "assistant at surgery" provides more than just ancillary services

ASSISTANT AT SURGERY

- Documentation Requirements
  - Assistant at surgery must be clearly identified in documentation
  - Operative note must reflect the medical necessity and the contribution(s) the assistant made to the case
  - The assistant at surgery is not required to document his/her own operative note
ASSISTANT AT SURGERY

Documentation Examples
- "The skilled assistance of (name) was necessary for the successful completion of this case. She was essential for (what assistance was provided)"
- A patient’s extreme condition may also be documented as medical necessity for an assistant at surgery
- Documentation will vary on a case by case basis

ASSISTANT AT SURGERY

- Services performed by a physician (MD or DO)
  - Modifier 80 – Assistant surgeon
  - Modifier 81 – Minimum assistant surgeon
  - Modifier 82 – Assistant surgeon (when qualified resident surgeon not available)
ASSISTANT AT SURGERY

- Services performed by a non-physician practitioner (NP or PA)
  - Modifier AS – Assistant at surgery service by non-physician practitioner

ASSISTANT AT SURGERY

- American College of Surgeons (ACS)
  - Evaluate surgical procedures and their need for a surgical assistant
  - Findings periodically published
ASSISTANT AT SURGERY

- ACS categorizes procedures by need for a surgical assistant
  - Almost always
  - Sometimes
  - Almost never
  - Per ACS, an indication that a physician would “almost never” be needed to assist at surgery for some procedures does NOT imply a physician is never needed

ASSISTANT AT SURGERY

- Medicare Physician Fee Schedule Indicators
  - 0 = Payment restrictions for assistant at surgery applies to this procedure unless supporting documentation is submitted to support medical necessity
  - 1 = Statutory payment restriction for assistants at surgery applies to the procedure — Assistant at surgery may not be paid
  - 2 = Payment restrictions for assistants at surgery does not apply to this procedure — Assistant at surgery may be paid
ASSISTANT AT SURGERY

Medicare Reimbursement

- Carriers may not pay assistants at surgery for surgical procedures in which a physician is used as an assistant at surgery in fewer than five percent of cases for that procedure nationally
  - This is determined through manual reviews
- Medicare Claims Processing Manual 100-04, Chapter 12, 20.4.3

ASSISTANT AT SURGERY

Medicare Reimbursement

- Physician acting as assistant at surgery – reimbursement equals 16% of the amount otherwise applicable for the global surgery
- NP or PA acting as assistant at surgery – reimbursement equals 85% of the 16% of the amount otherwise applicable for the global surgery
ASSISTANT AT SURGERY

Medicare Reimbursement Example

- CPT code 48105 (Resection or debridement of pancreas and peripancreatic tissue for acute necrotizing pancreatitis)
- MPFS Indicator = 2
- Allowed amount (Locality = 05302-99 Rest of Missouri) = $2,720.10
  - Assistant at surgery – physician ($2,720.10 x 16%) = $435.22
  - Assistant at surgery – NP or PA ($435.22 x 85%) = $369.93

RESOURCES

- Nurse Practitioner Scope of Practice
- Physician Assistant Scope of Practice
THANK YOU!

- Questions?
Section 1300.EXHIBIT A Sample Written Collaborative Agreement

ADVANCED PRACTICE NURSING
WRITTEN COLLABORATIVE AGREEMENT

A. ADVANCED PRACTICE NURSE INFORMATION

1. NAME: ____________________________________________________________

2. ILLINOIS RN LICENSE NUMBER: ________________________________
   ILLINOIS APN LICENSE NUMBER: ________________________________
   ILLINOIS MID-LEVEL PRACTITIONER LICENSE NUMBER: _____________
   FEDERAL MID-LEVEL PRACTITIONER DEA NUMBER: ________________

3. AREAS OF CERTIFICATION: _______________________________________

4. CERTIFYING ORGANIZATION: ____________________________________

5. CERTIFICATION EXPIRATION DATE: ________________________________

6. CERTIFICATION NUMBER: ________________________________________

7. PRACTICE SITES: (Attach List of Sites)

8. CONTACT NUMBER: _____________________________________________
   FACSIMILE NUMBER: ___________________________________________
   EMERGENCY CONTACT NUMBERS: _________________________________
   (e.g., pager, answering service)

9. ATTACHMENTS:
   Copy of Certification/Recertification
   Copies of RN & APN License
   Copy of Certificate of Insurance
   Copy of Mid-Level Practitioner License

B. COLLABORATING PHYSICIAN/PODIATRIST/DENTIST INFORMATION

1. NAME: __________________________________________________________
2. **ILLINOIS LICENSE NUMBER:** ______________________________

3. **PRACTICE AREA OR CONCENTRATION:** ______________________________

4. **BOARD CERTIFICATION (if any):** ______________________________

5. **CERTIFYING ORGANIZATION:** ______________________________

6. **PRACTICE SITES: (Attach List of Sites)**

7. **CONTACT NUMBER:** ______________________________
   **FACSIMILE NUMBER:** ______________________________
   **EMERGENCY CONTACT NUMBERS:** ______________________________
   (e.g., pager, answering service)

C. **ADVANCED PRACTICE NURSE COLLABORATING PHYSICIAN/PODIATRIST/DENTIST WORKING RELATIONSHIP**

1. **WRITTEN COLLABORATIVE AGREEMENT REQUIREMENT**

   A written collaborative agreement is required for all Advanced Practice Nurses (APNs) engaged in clinical practice outside of a hospital or ambulatory surgical treatment center (ASTC). An APN may provide services in a licensed hospital or ASTC without a written collaborative agreement or delegated prescriptive authority.

2. **SCOPE OF PRACTICE**

   Under this agreement, the advanced practice nurse will work with the collaborating physician or podiatrist in an active practice to deliver health care services to __________. This includes, but is not limited to, advanced nursing patient assessment and diagnosis, performing diagnostic and therapeutic tests and procedures, interpreting and using the results of diagnostic and therapeutic tests and procedures ordered by the APN or another health care professional, providing palliative and end-of-life care, providing advanced counseling, patient education, health education and patient advocacy, prescriptive authority, and delegating nursing activities or tasks to a LPN, RN or other personnel.

   If applicable, the advanced practice nurse shall maintain allied health personnel privileges at the following hospitals for the designated services:

   **Hospitals:** ______________________________
This written collaborative agreement shall be reviewed and updated annually. A copy of this written collaborative agreement shall remain on file at all sites where the advanced practice nurse renders service and shall be provided to the Illinois Department of Financial and Professional Regulation upon request. Any joint orders or guidelines are set forth or referenced in an attached document.

3. **COLLABORATION AND CONSULTATION**

Collaboration and consultation shall be adequate if the collaborating physician/podiatrist:

(A) participates in the joint formulation and joint approval of orders or guidelines with the advanced practice nurse, as needed based on the practice of the practitioners, and periodically reviews those orders and the services provided patients under those orders in accordance with accepted standards of medical practice and advanced practice nursing practice;

(B) meets in person with the APN at least once a month to provide collaboration and consultation; and

(C) is available in person, or through telecommunications, for consultation and collaboration on medical problems, complications or emergencies or for patient referral. (See 225 ILCS 60/54.5(b)(5).)

The written collaborative agreement shall be for services the collaborating physician or podiatrist generally provides to his or her patients in the normal course of clinical practice.

Information specific to collaboration and consultation with a CRNA is as follows:

(A) A licensed CRNA may provide anesthesia services pursuant to the order of a licensed physician, podiatrist or dentist.

(B) For anesthesia services, an anesthesiologist, physician, podiatrist or dentist participates through discussion of and agreement with the anesthesia plan and is physically present and available on the premises during the delivery of anesthesia services for diagnosis, consultation and treatment of emergency medical conditions.

(C) A CRNA may select, order and administer medications, including controlled substances, and apply appropriate medical devices for delivery of anesthesia services under the anesthesia plan agreed to by an anesthesiologist, or the operating physician, operating podiatrist or operating dentist. (See 225 ILCS 65/65-35(c-5) and (c-10).)

(D) In a physician's office, the CRNA may only provide anesthesia services if the physician has training and experience in the delivery of anesthesia.
services to patients.

(E) In a podiatrist's office, the CRNA may only provide those services the podiatrist is authorized to provide pursuant to the Podiatric Medical Practice Act.

(F) A collaborative agreement between a CRNA and a dentist must be in accordance with 225 ILCS 65/65-35(c-10). In a dentist's office, the CRNA may only provide those services the dentist is authorized to provide pursuant to the Illinois Dental Practice Act.

4. COMMUNICATION, CONSULTATION AND REFERRAL
The advanced practice nurse shall consult with the collaborating physician/podiatrist by telecommunication or in person as needed. In the absence of the designated collaborating physician/podiatrist, another physician/podiatrist shall be available for consultation.

The advanced practice nurse shall inform each collaborating physician/podiatrist of all written collaborative agreements he or she has signed with other physicians/podiatrists, and provide a copy of these to any collaborating physician/podiatrist upon request.

5. DELEGATION OF PRESCRIPTIVE AUTHORITY
As the collaborating physician/podiatrist, any prescriptive authority delegated to the advanced practice nurse is set forth in an attached document.

NOTE: ADVANCED PRACTICE NURSE MAY ONLY PRESCRIBE CONTROLLED SUBSTANCES UPON RECEIPT OF AN ILLINOIS MID-LEVEL PRACTITIONER CONTROLLED SUBSTANCES LICENSE.

WE THE UNDERSIGNED AGREE TO THE TERMS AND CONDITIONS OF THIS WRITTEN COLLABORATIVE AGREEMENT.

<table>
<thead>
<tr>
<th>Collaborating Physician/Podiatrist/Dentist</th>
<th>Advanced Practice Nurse</th>
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<td>Signature/Date</td>
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